

13047

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Accident Green</i>		c. LENGTH OF STAY IN lb <i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf (Rural)</i>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>LEONARD JOHN BENDER</i>		4. DATE OF DEATH Month <i>12</i> Day <i>16</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 8 1935</i>
9. AGE (In years last birthday) <i>22</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>FRED BENDER</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Ploor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		16. SOCIAL SECURITY NO. <i>54-56</i>	
17. INFORMANT <i>FRED BENDER</i>		Address <i>WALDORF MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>835X</i> DUE TO <i>Internal hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Tractor fell on him</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>12-16-57</i> <i>12-16-57</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Tractor turned over on him</i>	
20c. TIME OF INJURY Month, Day, Year <i>12-16-57</i> Hour <i>4:35</i> a. m. <input type="checkbox"/> p. m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Farm</i>		20f. (City or town) <i>Gallant Green</i> (County) <i>Charles</i> (State) <i>md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. E. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. E. EDELEN</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-19-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's Cem.</i>		22d. LOCATION (City, town, or county) <i>Bryantown md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HUNT FUNERAL HOME</i>		ADDRESS <i>WALDORF, md.</i>	
24a. REC'D BY REGISTRAR <i>Julia H. Hasey</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. Hasey</i>	
DATE <i>12/20/57</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

John Doe  
(R. L.)

BUREAU V. S.

DEC 23 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13043

13049

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG22, 1-3-58 et

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Welcome</b> c. LENGTH OF STAY IN 1b <b>26 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Welcome</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>WILLIAM</b> Last <b>BOWIE</b>		4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7/19/30</b>
9. AGE (In years last birthday) <b>27</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>10</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Station Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Benjamin F. Bowie</b>	
11. BIRTHPLACE (State or foreign country) <b>Benjamin F. Bowie</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Bowie</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Simpson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-4155</b>	
17. INFORMANT <b>Benjamin F. Bowie</b>		Address <b>Welcome, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R S Fisher MD</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		DATE SIGNED <b>12/12/57</b>	
22a. DATE OF REMOVAL (Specify) <b>12-14-57</b>		22b. DATE THEREOF <b>12-14-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Benjamin F. Bowie</b>		22d. LOCATION (City, town, or county) <b>Benjamin F. Bowie</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archie H. Laplate</b>		24. REC'D BY REGISTRAR DATE <b>12/16/57</b>	
24a. REGISTRAR'S SIGNATURE <b>John H. Casey</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Casey</b>	

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1003

STATE OF  
NEW YORK

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

MANNER OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PREVAILING DISEASE

PREVAILING CONDITION

PREVAILING SYMPTOM

PREVAILING SIGNS

PREVAILING TREATMENT

PREVAILING PROGNOSIS

PREVAILING OUTCOME

PREVAILING RESULT

PREVAILING EFFECT

PREVAILING INFLUENCE

*Handwritten signature*

BUREAU V. S.

DEC 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

13048 BPOC

CERTIFICATE OF DEATH

13042

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laplata</u> c. LENGTH OF STAY IN 1b <u>12</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phy. Mem. Hosp</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laplata</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Jones</u> Last <u>Burdette</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delumbre</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George A Jones</u>		14. MOTHER'S MAIDEN NAME <u>Eunice Morgan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Dorothy Morris Laplata</u>	
17. INFORMANT <u>Dorothy Morris Laplata</u>		Address <u>Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior Myocardial Infarction, acute</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>2 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 Dec.</u> , 19 <u>57</u> , to <u>24 Dec.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>23 Dec.</u> , 19 <u>57</u> , and that death occurred at <u>5:33 A</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>V.B. Detton</u> ADDRESS (Street, city or town, state) <u>Box 397 LAPLATA, MD</u> DATE SIGNED <u>24 DEC 1957</u> PHYSICIAN'S NAME (Type) <u>V.B. DETTON M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-27-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT West</u>		22d. LOCATION (City, town, or county) (State) <u>Laplata Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rehner Inc Laplata</u>		ADDRESS <u>12/30/57</u>	
24a. REC'D BY REGISTRAR <u>Julia H Pusey</u>		24b. REGISTRAR'S SIGNATURE	



CERTIFICATE OF DEATH

RECEIVED  
JAN 3 1968  
BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or interment.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13044

13050

Reg. Dist. No.

106

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head Md</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Brooklyn NY</u>	
3. NAME OF DECEASED (Type or print) First <u>Michael A.</u> Middle <u>Costagliola</u> Last <u>Costagliola</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W-US</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-10-34</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Enlisted-US-Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US-Army</u>	11. BIRTHPLACE (State or foreign country) <u>Brooklyn-NY.</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		17. INFORMANT Address <u>Eugene McEntee-Yoe-2C-, USN-Records</u>	
16. SOCIAL SECURITY NO. <u>1-21-57 to 12-18-57</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries Multiple Extreme</u> DUE TO <u>916.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Explosion 5-In. Rocket Fuse</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injury occurred when fuse exploded while patient was on duty at Stump Neck Annex, Naval Powder Factory Indian Head Md.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:30</u> a. m. <u>AM</u> <u>12-18-57</u> p. m.		20d. INJURY OCCURRED Nat while at work <input checked="" type="checkbox"/> Nat while at work <input type="checkbox"/> <u>Unknown</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Indian Head, Charles, Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		22b. DATE THEREOF <u>12-18-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>W.W. CHAMBERS CO</u>		22d. LOCATION (City, town, or county) (State) <u>New York City, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS CO</u>		24a. REC'D BY REGISTRAR <u>1400 CHAPIN ST NW</u>	
24b. REGISTRAR'S SIGNATURE <u>106</u>		DATE SIGNED <u>12-18-57</u>	

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 23 1957

RECEIVED



13045

13051

## CERTIFICATE OF DEATH

Reg. Dist. No.

107

1. PLACE OF DEATH a. COUNTY <u>Charles</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wayside</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wayside</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>E</u> Last <u>Edwards</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Jan 1, 1879</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>11</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>St Marys Co Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Thomas E Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Mary F Lloyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>John H. Edwards</u>		17. INFORMANT <u>Wayside</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mi</u> <u>5 year</u> <u>10 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>—</u> Day <u>—</u> Year <u>19</u> Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Howard</u> M. D. _____ PHYSICIAN'S NAME (Type) _____					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>	
22d. LOCATION (City, town, or county) (State) <u>Issuel</u> <u>Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Kaplata</u>		24. REC'D BY REGISTRAR DATE <u>12/17/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Julia H. Posen</u>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

page [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

1957

BUREAU V. 3

DEC 20 1957

RECEIVED

13052

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Victoria</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Victoria</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Fannie</i> Middle <i>SALES</i> Last <i>SALES</i>		4. DATE OF DEATH Month <i>DEC</i> Day <i>22</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 7</i>
9. AGE (In years lost birthday) <i>82</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>William Henry Dyson</i>		14. MOTHER'S MAIDEN NAME <i>Frances Anna Brown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Frances G. Thompson</i> Address <i>2913 Baker St. Balt. 16 Md.</i>		18. INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>_____</i> DUE TO (c) <i>_____</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>_____</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>out</i> , 19 <i>55</i> , to <i>12-22</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12-21</i> , 19 <i>57</i> , and that death occurred at <i>_____</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F. M. Johnson</i> M.D.		ADDRESS (Street, city or town, state) <i>LA PLATA Md.</i> DATE SIGNED <i>12-23-57</i>	
PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec. 26, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Shiloh M.E.</i>	22d. LOCATION (City, town or county) (State) <i>Hayside Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Funeral Home, Haldorf, Md.</i> ADDRESS <i>_____</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 30 '57</i>	24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

DEC 30 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

116

13053

1. PLACE OF DEATH a. COUNTY <u>Chas</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Adrian GARNER</u>				4. DATE OF DEATH Month Day Year <u>Dec 29 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 28, 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>RICHARD GARNER</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. WELCH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT Address <u>MRS Ruth Goldsmith BEL ALTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Collapse</u> DUE TO <u>C.U.A.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential hypertension</u> (c) <u>7 years ago</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>previous CUA</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>29 Dec</u> , 19 <u>57</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>30 Dec 57</u>							
ACTUAL SIGNATURE <u>Arthur Woodydy</u> M.D.				PHYSICIAN'S NAME (Type) <u>ARTHUR WOODYDY, MD</u> <u>LA PLATA, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-31-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Ignatius Cem</u>		22d. LOCATION (City, town, or county) (State) <u>BEL ALTON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HUNT Funeral Home WADSWORTH, MD.</u>				24a. REC'D BY REGISTRAR <u>3 JAN 3 1958</u> REGISTRAR'S SIGNATURE <u>John R. [unclear]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

JAN 3 1900

RECEIVED

## 13054 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, give date before admission) o STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b <u>Waldorf</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hosp.</u>		d. STREET ADDRESS <u>Waldorf</u>	
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>E.</u> Last <u>Glazeman</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>5</u> Year <u>1957</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jens Hansen</u>		14. MOTHER'S MAIDEN NAME <u>Anne Olson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>A. B. Glazeman</u>		Address <u>Waldorf, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>(Cardiac Arrest on 12-3-57)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>2 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 1951</u> to <u>December 5, 1957</u> that I last saw the deceased alive on <u>Dec 5</u> 1957, and that death occurred at <u>9:20 P M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Larson Jarboe</u>		DATE SIGNED <u>12-5-57</u>	
PHYSICIAN'S NAME (Type) <u>J. PARRAN JARBOE, M.D.</u>		ADDRESS <u>La Plata, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>12-7-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LEE FUNERAL HOME</u>	22d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>WALDORF, MD</u>	24b. REGISTRAR'S SIGNATURE <u>Julia H. Boney</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 11 1977

RECEIVED

13055

## CERTIFICATE OF DEATH

Reg. Dist. No. 1-0

1 PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>X2 Waldorf</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hosp.</b>		d. STREET ADDRESS <b>1</b>	
3 NAME OF DECEASED (Type or print) <b>JULIANA</b> First Middle Last <b>LANGLEY</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>20</b> Year <b>19 57</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-25-74</b>
9. AGE (In years last birthday) <b>83</b> yrs		IF UNDER 1 YEAR: Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unk</b>		14. MOTHER'S MAIDEN NAME <b>unk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Clements Langley</b>		Address <b>Waldorf, Md.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b> <b>H20.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>18 Dec.</b> 19 <b>57</b> , to <b>20 Dec.</b> 19 <b>57</b> , that I last saw the deceased alive on <b>20 Dec.</b> 19 <b>57</b> , and that death occurred at <b>10:01 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>V. B. DETTOR</b>		ADDRESS (Street, city or town, state) <b>LA PLATA, MARYLAND.</b> DATE SIGNED <b>12-22-57</b>	
PHYSICIAN'S NAME (Type) <b>V. B. DETTOR, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-23-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Peters Cem.</b>	22d. LOCATION (City, town or county) (State) <b>Waldorf, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>		ADDRESS <b>Waldorf, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>12/30/57</b>		24b. REGISTRAR'S SIGNATURE <b>Walter H. Casey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 8 1963

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13051

Reg. Dist. No. 100

13056

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Iron side md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Jerome</u> Middle <u>David</u> Last <u>Montgomery</u>		<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>25</u> Year <u>1957</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Eol</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Jan 2 1929</u>	<b>9. AGE</b> (In years last birthday) <u>25</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>25</u> Days <u>25</u> <b>IF UNDER 24 HRS.</b> Hours <u>25</u> Min. <u>25</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Gov. worker</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Charles co</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>Russell Montgomery</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Evelyn A. Mianlow</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <u>Survivor Montgomery Indian Head</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock &amp; Hemorrhage</u> 981X DUE TO <u>Gun Shot Wound of left face</u> Conditions, if any, which gave rise to immediate cause (b) <u>2-3 min.</u> (c), stating the underlying cause lost. DUE TO <u>2-3 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDIT ON GIVEN IN PART I (a)			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input checked="" type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Shot gun wound</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>6:10 P.M. 12 25 1957</u>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	<b>20f. (City or town)</b> <u>Indian Head, Charles Md.</u> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>V. B. DETTOR, M.D.</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b>		<b>DATE SIGNED</b> <u>12-25-57</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Bural</u>		<b>22b. DATE THEREOF</b> <u>11/29-57</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Montgomery Brothers Funeral Home</u>		<b>22d. LOCATION (City, town or county)</b> <u>Iron Side Md.</u> (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Montgomery Brothers Funeral Home</u>		<b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <u>DATE 12/25/57</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

BUREAU V. S.

JAN 8

RECEIVED

13057

Item 2: **CERTIFICATE OF DEATH**

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPLATA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial</b>		d. STREET ADDRESS <b>---</b>	
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>MOORE</b> Last <b>MOORE</b>		4. DATE OF DEATH Month <b>DEC</b> Day <b>28</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 28 1957</b>
9. AGE (In years last birthday) <b>2</b> years		IF UNDER 1 YEAR Months <b>2</b> Days <b>45</b>	IF UNDER 24 HRS. Hours <b>45</b> Min <b>45</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Laplatas and</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward H. Moore</b>		14. MOTHER'S MAIDEN NAME <b>Jannet Marie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Edward H. Moore</b>	
17. INFORMANT <b>Edward H. Moore</b>		Address <b>Waldorf Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory collapse</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chondrodysplasia (achondroplasia)</b> DUE TO (c) <b>2 hrs. 45 min.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-28</b> 19 <b>57</b> , to <b>12-28</b> 19 <b>57</b> , that I last saw the deceased alive on <b>12-28</b> 19 <b>57</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. M. JOHNSON</b> M.D.		ADDRESS (Street, city or town, state) <b>Laplatas Md.</b> DATE SIGNED <b>12-28-57</b>	
22a. BURIAL, CREMAT., OR REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>12-28-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's</b>		22d. LOCATION (City, town, or county) (State) <b>Waldorf Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Mc Laplata</b> ADDRESS <b>Waldorf Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 31 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>Julia Posey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD V. S.

DEC 22 1967

RECEIVED

13053

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Thompskinsville md</u> , MARYLAND		2. USUAL RESIDENCE (Where deceased resided, if institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles Co</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH MOORE</u>		4. DATE OF DEATH <u>DEC 22 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov 2 1883</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Co</u>	
13. FATHER'S NAME <u>George Howard</u>		14. MOTHER'S MAIDEN NAME <u>Lena Colbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		17. INFORMANT <u>Carrie Thomas Thompskinsville md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition and debility</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>J. B. Detton</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>J. B. DETTOR, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>		22d. LOCATION (City, town, or county) (State) <u>Issue md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archard Mc Saplata md</u>		24a. REC'D BY REGISTRAR <u>Julia H. Casey</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>12/30/57</u>	



RECEIVED

JAN 8 1953

BUREAU V. S.

13059

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomfret</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomfret</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>FRANCIS</u> First <u>MUDD</u> Middle <u>MUDD</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-01</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. MUDD</u>		14. MOTHER'S MAIDEN NAME <u>Constance MUDD.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>213 38 224</u>	
17. INFORMANT <u>Evelyn MUDD</u> Address <u>Pomfret, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>Heart</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gen. ART Sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12-6-57</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-10-1957</u> to <u>12-6-1957</u> , that I last saw the deceased alive on <u>1-27-57</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Lafayette</u> DATE SIGNED <u>12-8-57</u> ACTUAL SIGNATURE <u>E. J. EDELEN</u> M.D. PHYSICIAN'S NAME (Type) <u>E. J. EDELEN MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-9-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Joseph's</u>	22d. LOCATION (City, town, or county) (State) <u>Pomfret, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u> ADDRESS <u>WALCROFT MD.</u>		24a. REC'D BY REGISTRAR DATE <u>12/9/57</u>	24b. REGISTRAR'S SIGNATURE <u>Julia H. Harey</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13060

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## 13055

Reg. Dist. No. 100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Doncaster</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Doncaster</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or print) First: <u>James</u> Middle: <u>Alfred</u> Last: <u>Myatt</u>				<b>4. DATE OF DEATH</b> Month: <u>12</u> Day: <u>5</u> Year: <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-23-1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months:      Days:		IF UNDER 24 HRS. Hours:      Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Walter Myatt</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Stallings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. 		17. INFORMANT Address <u>Mrs. Esther Blandy, Smithfield, N.C.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>                      IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>                      DUE TO                      Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:                      (b) <u>Coronary Artery Occlusion</u>                      DUE TO                      (c) <u>Arteriosclerotic Heart Disease.</u> </div> <div style="width: 15%;">                     INTERVAL BETWEEN ONSET AND DEATH  <u>Minutes</u>   <u>Minutes</u>   <u>Years</u> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>None known</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY      Month, Day, Year Hour: <u>6</u> a.m.      p.m. <u>12-5-1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Doncaster Charles Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Vernon B. Dettor</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-7-'57</u>	
EXAMINER'S NAME (Type) <u>Vernon B. Dettor, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12-7-57</u>		22c. NAME OF CEMETERY OR CREMATORY 		22d. LOCATION (City, town, or county) (State) <u>Smithfield N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Fontt Funeral Home, Weldoy Md</u>				24a. REC'D BY REGISTRAR DATE <u>12/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Hosen</u>	

DONALD V. R

EC

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13061 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13056

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u> d. STREET ADDRESS _____ IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
--	--	---	--

<b>3. NAME OF DECEASED</b> (Type or print) <u>George Arthur</u> First <u>Robey</u> Middle Last <b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Jan 4, 1910</u> <b>9. AGE</b> (In years last birthday) <u>47</u> yrs.			<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>22</u> Year <u>1957</u> <b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min _____		
---	--	--	---	--	--

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Gov</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>
---	--	--

<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	<b>13. FATHER'S NAME</b> <u>James L. Robey</u>
---	--

<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary J. Lipson</u>	<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____	<b>16. SOCIAL SECURITY NO.</b> <u>218-37-2715</u>
---	--	---

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH _____
---	--	--

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>	<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	---

<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour _____ a. m. _____ p. m. _____ 19____ <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____
--	---

**21. I certify that I took charge of the remains described above, held an Autopsy** ☒ **Inspection** ☐ **Inquiry** ☐ **and find that death resulted from:** Natural causes ☒ **Accident** ☐ **Suicide** ☐ **Homicide** ☐ **Undetermined cause** ☐.

<b>ACTUAL SIGNATURE</b> <u>William Updell</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> _____ <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> _____ <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>	<b>DATE SIGNED</b> <u>12-22-57</u>
---	---------------------------------------

<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>Dec. 26, 1957</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Sacred Heart</u>
--	---	---

<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hunt Funeral Home</u>	<b>24a. RECEIVED BY REGISTRAR</b> <u>John Posey</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>John Posey</u>
--	---	---

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU Y. K.

DEC 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 48 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registry prior to burial, cremation, or other disposition.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13057

Reg. Dist. No. 106

13062

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) b. STATE <b>Rhode Island</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Providence, RI</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stump Neck Naval Powder Factory Annex Indian Head Md.</b>		c. LENGTH OF STAY IN 1b <b>Unknown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Powder Factory Dispensary Indian Head Md.</b>		d. STREET ADDRESS <b>789-Groenville Ave. Johnson, RI</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sanderson, Nelson Lloyd</b>		4. DATE DEATH <b>12-18-57</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>W-US</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-19-39</b>
9 AGE (in years last birthday) <b>18</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USAF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>	
11. BIRTHPLACE (State or foreign country) <b>Providence RI.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>9-13-56</b>	
17. INFORMANT <b>Eugene McEntee-Yoe.-2C-USN-Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Injuries Multiple Extreme</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Explosion 5In.Rocket Fuse</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Injury occurred when a 5-In.Rocket fuse exploded while patient was on duty at Stump Neck Annex, Naval Powder Factory, Indian Head Md.</b>	
20c. TIME OF INJURY Month, Day, Year <b>9:30 a.m. 12-18-57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>Unknown</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Unknown</b>		20f. (City or town) (County) (State) <b>Indian Head Charles, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James E. Andrews</b>		DATE SIGNED <b>12-18-57</b>	
EXAMINER'S NAME (Type) <b>James E. Andrews MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>		22b. DATE THEREOF <b>12-18-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sharon Point Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Providence Rhode Island</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chamber Co. 517-11th St. S.E.</b>		24. REC'D BY REGISTRAR <b>DATE</b>	
24b. REGISTRAR'S SIGNATURE <b>Oliver Price</b>			

WILLIAM V. S.

1877

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13063

## CERTIFICATE OF DEATH

Reg. Dist. No. 13058

1. PLACE OF DEATH o COUNTY <i>Charles Co</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Point Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phyman Health</i>				d. STREET ADDRESS _____			
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle _____ Last <i>SMOTHERS</i>				4. DATE OF DEATH Month <i>Dec</i> Day <i>14</i> Year <i>1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 8, 1890</i>		9. AGE (In years last birthday) <i>67</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labourer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Labourer</i>		11. BIRTHPLACE (State or foreign country) <i>Charles Co</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lenny</i>				14. MOTHER'S MAIDEN NAME <i>Mary Young</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT <i>Blanch Smothers (Wife)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Squamous Cell Carcinoma of face</i> 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <i>Sept 14, 1956</i> to <i>14 Dec 1957</i> , that I last saw the deceased alive on <i>15 Dec 1957</i> , and that death occurred at <i>2:10 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>F. M. Johnson</i> M.D.				ADDRESS (Street, city or town, state) <i>Rd. 1, P.O. Box 12-17-57</i> DATE SIGNED <i>12-17-57</i>			
PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-16-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Holy Ghost</i>		22d. LOCATION (City, town, or county) (State) <i>Issue Md. Charles Co</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Orlando Inc</i>				ADDRESS <i>Issued Md</i>		24a. REC'D BY REGISTRAR DATE <i>12/20/57</i>	
				24b. REGISTRAR'S SIGNATURE <i>Julia H. Casey</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES

DEC 28 1957

RECEIVED

13064

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <i>Md</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saplatata Md</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X: Rock Point Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>St Marys Mem Hosp</i>				d. STREET ADDRESS <i>1</i>			
3. NAME OF DECEASED (Type or print) <i>SHARON ANN SMOTHERS</i>				4. DATE OF DEATH Month <i>DEC</i> Day <i>9</i> Year <i>1957</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 28, 1954</i>	9. AGE (In years last birthday) <i>3</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Rock Point</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John W. Smathers Jr</i>				14. MOTHER'S MAIDEN NAME <i>Lessie C. Dyson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <i>John W. Smathers Jr</i>		17. INFORMANT Address <i>Rock Point Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>3rd degree burns over 1/5 body</i> <i>416.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Kerosene stove blew up</i>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Rock Pt.</i>	(County) <i>Chas.</i>	(State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>12-7-57</i> , to <i>12-9-57</i> , that I last saw the deceased alive on <i>12-9-57</i> , and that death occurred at <i>9:15 PM</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Dr. J. L. Plata</i>				ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>12-9-57</i>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>12-11-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Ghost</i>	22d. LOCATION (City, town, or county) <i>Chas.</i>	(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chehart Inc</i> ADDRESS <i>Saplatata Md</i>			24a. REC'D BY REGISTRAR DATE <i>12/16/57</i>	24b. REGISTRAR'S SIGNATURE <i>Julia M. Posey</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 10 1917

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13065 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13060

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>D. CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTSVILLE</u>		c. LENGTH OF STAY IN TB _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENVILLE MD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HANS</u> Middle <u>OTTO</u> Last <u>STASCH</u>				4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-11</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ST MARYS CO</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>AUGUST</u>				14. MOTHER'S MAIDEN NAME <u>DORTHFA RADIES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>OTTO H STASCH</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>222x</u> DUE TO <u>Couflagration in Crusher Chert</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tractor turned over on him</u> DUE TO <u>and caught fire</u> (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12-12-57</u> <u>12-12-57</u>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tractor turned over on him &amp; caught fire</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12</u> p. m. <u>12</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. City or town <u>Dentsville</u>	(County) <u>St</u>	(State) <u>MD</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. J. EDELEN</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST PAULS</u>		22d. LOCATION (City, town, or county) (State) <u>CHARLOTT HALL MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archard G. C. Spilata mal</u>				24a. REC'D BY REGISTRAR DATE <u>12/17/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Pacey</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13066

Item 12.11 Film 3223 12-27-57 et

## CERTIFICATE OF DEATH

13066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X'd Rock Point</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>AGUSTUS</u> Middle <u>STINE</u> Last <u>STINE</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 24 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Optic &amp; Finisher</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Raymond Stine</u> Address <u>Rock Point</u>	
17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Pulmonary Embolism</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>3 weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5:50 p.m.</u> <u>12 12 1957</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rock Point, Charles, Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>29 Oct.</u> 19 <u>57</u> , to <u>29 Nov.</u> 19 <u>57</u> , that I last saw the deceased alive on <u>29 Nov.</u> 19 <u>57</u> , and that death occurred at <u>8:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vernon B. Dettor</u>		ADDRESS (Street, city or town, state) <u>Bix 397, LA PLATA, MD.</u> DATE SIGNED <u>14-Dec-1957</u>	
PHYSICIAN'S NAME (Type) <u>VERNON B. DETTOR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>	22d. LOCATION (City, town, or county) (State) <u>md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Mc LaPlata</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>12/17/57</u>	24b. REGISTRAR'S SIGNATURE <u>Julia H. Pusey</u>

THOMAS V. S.

RECEIVED

## 13067 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> <i>and</i> <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phy</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tompkinsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Mary's Hosp.</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Warren Bisco Thompson</i>		4. DATE OF DEATH Month Day Year <i>12 - 12 1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/17/1896</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Remuel Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Oliver Bailey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Julien Thompson</i>		Address <i>Tompkinsville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <i>Acute Coronary Occlusion</i> DUE TO <i>Arteriosclerotic Cardiovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>3 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 5</i> , 19 <i>57</i> , to <i>Dec 13</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Dec 13</i> , 19 <i>57</i> , and that death occurred at <i>4:25</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Parran Jarboe</i>		ADDRESS (Street, city or town, state) <i>La Plata Md</i>	
PHYSICIAN'S NAME (Type) <i>J. PARRAN JARBOE</i>		DATE SIGNED <i>12-13-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>12-16-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Ghost</i>		22d. LOCATION (City, town, or county) (State) <i>2 mi md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archibald Mc LaPlata</i>		24a. REC'D BY REGISTRAR DATE <i>12/16/57</i>	
24b. REGISTRAR'S SIGNATURE <i>Julius H. Hasey</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

DEC

RECEIVED

## 13068 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrettsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Mem. Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Sebastian</u> First Middle Last <u>Welch</u>		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1886</u> 9. AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bealy Welch</u>		14. MOTHER'S MAIDEN NAME <u>Lushan Howell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Myrtle Miller, Waldorf, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>551X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>12-12-57</u> <u>1951</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1952</u> , 19 <u>52</u> , to <u>12-15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-15</u> , 19 <u>57</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>La Plata, Md.</u> DATE SIGNED <u>12-16-57</u> ACTUAL SIGNATURE <u>E. J. Edele</u> M.D. <u>E. J. EDELEN</u> PHYSICIAN'S NAME (Type) <u>E. J. EDELEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 18, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>La Plata, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home, Waldorf, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>12/20/57</u>	24b. REGISTRAR'S SIGNATURE <u>J. H. Gasey</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JAN 21 1964  
U. S. DEPARTMENT OF  
COMMERCE  
WASHINGTON, D. C.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13064

13069

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO La Plata, Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Washington Wills</b> First Middle Last				4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>w</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/10/1898</b>		9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Business Executive Del Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Del Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. Charles Co.</b>	
13. FATHER'S NAME <b>Frederick Wills</b>				14. MOTHER'S MAIDEN NAME <b>Bowling</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>100-41</b>		17. INFORMANT <b>Blockborn Wills LaPlata</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>816x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Crushed Chest</b> (c) <b>Auto Accident</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12-7-10-57</b> <b>12-2-57</b> <b>12-2-57</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of auto hit by trailer truck</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12:00</b> p.m. <b>12</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway 301</b>		20f. (City or town) (County) (State) <b>La Plata Ches Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>E. J. EDELEN</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. J. EDELEN</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-13-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>S. Thomas</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert M. LaPlata</b>				ADDRESS <b>La Plata</b>		24a. REC'D BY REGISTRAR DATE <b>12/16/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Julius H. Passy</b>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# STATE OF MARYLAND Item 11 Film 0223 12-27-57 et CERTIFICATE OF DEATH

13070

13065

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>				c. LENGTH OF STAY IN 1b <i>X2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Phy Mem. Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Jeane Elaine</i> First Middle Last <i>XATES</i>				4. DATE OF DEATH Month <i>Dec</i> Day <i>14</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>17 Feb 57</i>	
9. AGE (In years last birthday) <i>10</i> yrs.		IF UNDER 1 YEAR Months <i>3</i> Days <i>1</i>		IF UNDER 24 HRS. Hours <i>+</i> Min. <i>+</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>more</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>La Plata, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>							
13. FATHER'S NAME <i>William L. Yates</i>				14. MOTHER'S MAIDEN NAME <i>Hester Ann Barton</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>William L. Yates</i> Address <i>Saplata md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Collapse</i> <i>241 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bronchial pneumonia.</i> DUE TO (c) <i>allergic bronchitis.</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i> <i>2 days</i> <i>6 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>17 Feb</i> , 19 <i>57</i> , to <i>14 Dec</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>14 Dec</i> , 19 <i>57</i> , and that death occurred at <i>8:00 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED							
ACTUAL SIGNATURE <i>Dr. Wooddy</i> M.D. <i>La Plata, Md.</i>							
PHYSICIAN'S NAME (Type) <i>ARTHUR O. WOODDY, MD.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-16-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>		22d. LOCATION (City, town, or county) (State) <i>Saplata md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arphart Inc</i> ADDRESS <i>Saplata md.</i>				24a. REC'D BY REGISTRAR DATE <i>12/17/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. Casey</i>	

2066313XV6

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

BUREAU V. S.

JEC 00 1957

RECEIVED